

<b>Chapter 7 Reference Edits 4000-4999</b>				
<b>Individual Updates</b>				
<b>Document Version Number</b>	<b>Revision Date</b>	<b>Revision Page Number(s)</b>	<b>Reason for Revisions</b>	<b>Revisions Completed By</b>
Version 7.2	June 30, 2006	Various	Update edits 4014, 4164, 4165, 4234, 4235, 4236, and 4237.	Leo Dabbs
<b>Version 7.4</b>	<b>November 8, 2006</b>	<b>Multiple</b>	<b>4010, 4012, 4013, 4014, 4019, 4022, 4027, 4029, 4039, 4040, 4041, 4041, 4043, 4044, 4045, 4046, 4047, 4049, 4050, 4051, 4052, 4060, 4065, 4067, 4090, 4091, 4098, 4117, 4119, 4129, 4130, 4131, 4132, 4133, 4134, 4136, 4137, 4138, 4139, 4140, 4142, 4162, 4163, 4203, 4226, 4227, 4234, 4235, 4236, 4237</b>	<b>Anson Haley</b>

**Edit: ESC 4010 Modifier Requires Medical Review***Note: Edit 4010 revised October 27, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	04	All	Detail	Yes	Yes	0

Disposition	M	B
Other	Suspend	Suspend
Paper w/o attach	Deny	Deny
Paper w/attach	Suspend	Pay
ECS w/o attach	CCF	Inactive
Shadow	Pay	Deny
Elec. Crossover PES	Deny	Deny
Point of Service w/o attach	Suspend	N/A
Voids/Replacement non-check related	Inactive	Pay
Voids/Replacement check related	Inactive	Pay
Shadow Replacement	Pay	Deny
Mass Replacement NH	Inactive	Suspend
Mass Replacement FIN	Inactive	Suspend
Elec. Replacement w/attach or claim note	Deny	Deny
Elec. Replacement w/o attach or claim note	CCF	Deny
Spend-down EOM auto-initiated Mass Replacement	Inactive	Suspend
Payer Elec. Replacement	CCF	Inactive
Claims Reprocessed by EDS SE	Deny	Deny
Special Batch	Suspend	Deny

**Edit Description**

Fail this edit if the indicator on the modifier table is set for medical review.

**Edit Criteria**

If the indicator on the modifier table is of the type Review, and accompanying documentation does not support the service billed, fail this edit with EOB 4010 or EOB 9011.

**EOB Code**

4010 – The documentation submitted does not support this billing.

9011 – Supporting documentation is needed for the modifier(s) submitted.

4033 – The modifier used is not compatible with the procedure code billed. Please verify and resubmit.

**ARC Code**

17 - Payment adjusted, because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remark codes, whenever appropriate.

**Remark Code**

N66 – Missing/Incomplete/Invalid Documentation

**N225 - Incomplete/invalid documentation/orders/notes/summary/ report/chart.**

**Method of Correction**

The analyst needs to identify that proper documentation is included to support the billing of this procedure code and modifier combination. Force the edit if proper documentation is present.

If a surgical procedure code (10000-69999) is billed with a 62 modifier (two surgeons), verify that there is a value of one or two in the Co-Surgeons field on the MFSDB. Access the MFSDB by logging into IndianaAIM, then click on Reference, then HCPC Procedure, then type in the procedure code, then go up to the Options menu and hold down on the right mouse button and go down to Pricing then over to RBRVS and release the mouse button. This table is the MFSDB and on this table, scroll all the way over to the right so that the Co-Surgeons field is showing. If the procedure code has a value of one or two, calculate the allowed amount by multiplying the RBRVS fee amount for the billed surgical procedure code times .625 (62.5%) and override the audit.

*Note: The allowed reimbursement amount should be the lesser the RBRVS fee amount times .625 (62.5%), or the billed amount.*

If the Co-Surgeons field on the MFSDB does not have a value of one or two, deny the claim with EOB 4033.

If the documentation for review is not present, deny the claim with EOB 9011.

**Edit: ESC 4012 Abortion Diagnosis/Procedure Indicated***Note: Edit 4012 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M, O, A, B, C	22	All	Detail	Yes	Yes	0

Disposition	M, O	A, B, C
Other	Suspend	Suspend
Paper w/o attach	Suspend	Deny
Paper w/attach	Suspend	Deny
ECS w/o attach	Suspend	Deny
ECS w/attach	CCF	Deny
Shadow	Pay	Deny
Elec. Crossover PES	Suspend	CCF
Point of Service w/o attach	Deny	Deny
Voids/Replacement non-check related	Inactive	Inactive
Voids/Replacement check related	Inactive	Inactive
Shadow Replacement	Pay	Deny
Mass Replacement NH	Inactive	Inactive
Mass Replacement FIN	Inactive	Inactive
Elec. Replacement w/attach or claim note	Deny	Suspend
Elec. Replacement w/o attach or claim note	Suspend	CCF
Spend-down EOM auto-initiated Mass Replacement	Inactive	Inactive
Payer Elec. Replacement	Suspend	Deny
Claims Reprocessed by EDS SE	Deny	Deny
Special Batch	Suspend	Suspend

**Edit Description**

Fail this edit when a claim is submitted with a diagnosis or procedure code indicating an elective abortion was performed.

**Edit Criteria**

If a claim is submitted with a diagnosis or procedure code indicating an elective abortion was performed, fail this edit. See attached list of diagnosis and procedure codes.

**EOB Code**

4012 – Claim denied for additional information. If the abortion was performed for therapeutic or other Medicaid approved purposes, please resubmit the claim with a Physician Certification Form and medical record documentation (H & P, discharge summary, OP note).

**ARC Code**

**16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.**

**Remark Code**

**N29 - Missing documentation/orders/notes/summary/report/chart.**

**Method of Correction**

Route the claim to the medical policy specialist.

Medical Policy Specialist Instructions:

Check for the presence of medical documentation. If no documentation is present, deny the claim.

If medical documentation is present, and it substantiates one of the diagnosis codes listed on diagnosis group 10 (see *Appendix A*), fail this edit with EOB 4012.

If a claim is not miscoded, the claim must be accompanied by the following:

- *Physician Certification for Abortion* form which states the abortion was necessary to preserve the life of the pregnant woman.
- The medical record which supports the physician's abortion certification statement.

If the documentation indicates abortion was performed following rape or incest, forward the claim and all attachments to the director of Medicaid Operations. The medical policy specialist is to review all claims suspending for this edit with the medical policy manager. Each claim forwarded to Medicaid Operations will be entered on a tracking form maintained by the medical policy manager.

If certification or medical documentation is not attached or completed, deny the claim with EOB 4012.

If medical documentation and certification (which includes patient's name, address, date of service, physician name and physician signature) are attached, override the error and force the claim to pay. A diagnosis is not required on the physician certification form.

Photocopy the claim, physician certification form, and medical record and file in the abortion file until needed for the quarterly abortion report.

Claims with region 62-Electronic Replacements without attachments will CCF back to the provider for appropriate documentation.

Suspend medical and outpatient claim types if any of the ICD-9 diagnosis codes listed on diagnosis group 10 (see appendix) are present on the claim.

Suspend medical and outpatient claims if any of the HCPCS procedure codes listed on procedure group 57 are present on the claim.

*Note: If the medical policy specialist is unsure of the decision to be made, forward the claim to the medical policy supervisor or medical director.*



**Edit: ESC 4013 Procedure Code Is Not Covered for Date of Service***Note: Edit 4013 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, M, O, Q	04	All	Detail	Yes	Yes	0

Disposition	D, H, I, M, O, Q
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Suspend

**Edit Description**

Fail this edit if the procedure code is no longer effective for the service dates submitted on the claim.

**Edit Criteria**

If the date of service on the claim form is not within the effective and end date on the HCPCS Limits/Restrictions Table, fail this edit with EOB 4013.

**EOB Code**

4013 – This procedure code is not covered for this date of service.

**ARC Code**

**181 – Payment adjusted because this procedure code was invalid on the date of service.**

**Remark Code**

**M67 – Missing, incomplete, or invalid other procedure code(s).**

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4014 No Pricing Segment on File***Note: Edit 4014 revised October 27, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, I, L, M, O, P, Q	04	All	Detail	No	Yes	0

Disposition	D, H, I, L, M, O, B	P & Q
00 Other	Suspend	Deny
10 Paper w/o attach	Suspend	Deny
20 ECS w/o attach	Suspend	Deny
22 Shadow	Pay	Pay & List
25 Point of Service w/o attach	Suspend	Deny
50 Voids/Replacement non-check related	Suspend	Deny
51 Voids/Replacement check related	Deny	Deny
52 Shadow Replacement	Pay	Deny
53 Shadow Claim Void	Suspend	Deny
55 Mass Replacement NH	Deny	Deny
56 Mass Replacement FIN	Suspend	Deny
90 Special Projects	Suspend	Deny
Adjustments	Deny	Deny

**Edit Description**

Fail this edit if no pricing segment is on file for the service dates.

**Edit Criteria**

If no pricing segment is on file for the dates of service, fail this edit with EOB 4014.

**EOB Code**

4014 – No pricing segment is on file.

8327 – Billing and/or rendering provider number invalid for waiver services billed.

4107 – Revenue Code is not appropriate/not covered for the type of service being provided.

**ARC Code**

133 – The disposition of this claim/service is pending further review.

**Remark Code**

None.

**NCPDP Reject Code**

70 – NDC not covered.

**Method of Correction**

If waiver services are being billed, and the rendering provider number is not a care coordinator or case manager specialty, or billing provider number is not a waiver provider specialty, fail this edit with EOB 8327.

Verify there is no pricing segment on file for service billed.

If no pricing is on file, then the Medical Policy Unit should establish and update the affected reference file.

- For Outpatient Claims that are billing revenue codes 920 or 940, deny using EOB 4107. These procedures are not to be billed or paid on an outpatient claim form. Refer to the Banner dated 2005/02/15.
- For Claims that are billing revenue code 780 (Telemedicine) with a procedure code other than Q3014, deny using EOB 4107. Refer to Telemedicine Bulletin for more information.

**First Steps Claims:**

When First Steps Claims fail Edit 4014, examine the claims to ensure that all pricing requirements are present. The procedure code is billed with required modifier TL- the required taxonomy

If the taxonomy missing, deny the claim with EOB 6815: Required Taxonomy Missing.

If a taxonomy is present:

1. Double on the procedure code
2. Click on Options
3. Hover over pricing, then double click on First Steps Max Fee
4. Check the Taxonomy list to see if the Taxonomy on the claim is in the list on the window. If no, Deny the claim with EOB 4222-*The Taxonomy Code Submitted is not Valid* (Remember, the window will only display the first four characters)

**Procedure Group 183**

- **If the procedure code is on the Procedure is on the Procedure Group 183 (Assertive Technology)**
- **Check to see if there is a dollar amount for the procedure code on the Prior Authorization window. If there is a dollar amount on the Prior Authorization window, put this amount in the allowed amount on the claim in the allowed amount field. NOTE: The allowed amount cannot be more than the billed amount.**

- **If there is no dollar amount approved for the procedure code, and the date of service on the claim, deny the edit 4014 and add EOB 3006. EOB 3006-P.A. Dollars Exhausted.**

To check to verify if the procedure is on Procedure Group Table 183-Assertive Technology:

- Double click on the procedure code on the claim
- Click on options
- Click on the HCPC Procedure Group

This will bring up a list of all procedure groups associated with this procedure code. Examine the list for Procedure Group 183.

If the claim fails this edit, and the procedure code is not on the First Steps Max Fee Table, or on Procedure Group 183, deny the claim and email the ICN to the Team Coordinator or Supervisor.

#### PROCEDURE CODE:

99510 TL52 is Home Visit for individual, family or marriage counseling; therefore, there is not an Onsite rate. Deny the claim for the following Place of Service.

04	05	06	07	08
11	15	20	21	22
23	24	25	26	31
32	34	49	50	51
52	53	54	55	56
57	60	62	65	71
72	81			

**Edit: ESC 4019 Procedure Code Requires Attachment**

<i>Note: Edit 4019 revised October 27, 2006</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
D, H, M, O	04	All except MRT and PASRR	Detail	Yes	Yes	0

Disposition	D, H, M, O, P, Q
Paper Claim	Deny
Paper w/attachment	Suspend
ECS	CCF
Shadow	Pay
POS	N/A
Adjustments	N/A
Special Batch	Suspend

**Edit Description**

Fail this edit if the procedure code billed has an attachment indicator on the reference database and the claim has no attachments.

**Edit Criteria**

If the billed procedure has an attachment indicator on the reference database and no attachment is submitted with the claim, fail this edit with EOB 4019.

For medical claim (M) types, any procedure code billed that is listed on procedure group 48 (see *Appendix A*) must have an attachment or the claim will fail this edit with EOB 4019.

**EOB Code**

4019 – Attachment required for service rendered – please verify and resubmit.

4072 – An attachment is required for the service rendered. Please submit with the *Claim Correction Form*.

**ARC Code**

**16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.**

**Remark Code**

**N29 - Missing documentation/orders/notes/summary/report/chart.**

**Method of Correction**

Check for any keying errors and correct any found.

Verify the care coordination outcome report form was submitted with the claim, if not, deny the claim.

If the form is with the claim, verify information for items one through 18 is complete. If any of the blocks are not completed, deny the claim.

If a properly completed form is submitted, force the edit and make a copy of the outcome report so it can be forwarded to the State.

Paper claims without an attachment failing this edit will systematically deny.

Effective December 6, 2002, when processing claims for any attachment edits, see if there is an attachment from Medicare or other insurance. Check the claim and supporting documentation for mismatched procedure codes. Because of I letter 20010321, from the OMPP, it is imperative claims are paid only if the code billed to Medicaid is the same code that was originally billed to Medicare. The only exception is if a K code is billed to Medicare and subsequently billed to Medicaid as an E code, when Medicaid does not cover the K code. The following codes can be switched between Medicare and Medicaid: G codes, anesthesia codes billed to Medicare with 00\*\*\*, and A0425. If the codes are switched or mismatched the claim will be denied with EOB 2508-*Your service has been denied*. The code billed to Medicaid was not the code billed to the primary insurer.

**Edit: ESC 4022 Abortion Diagnosis/Procedure Indicated***Note: Edit 4022 revised October 27, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I, O	22`	All	Header	Yes	Yes	0

Disposition	I, O
Paper Claim	Suspend
ECS	Suspend
Shadow	Pay
POS	N/A
Adjustments	N/A
Special Batch	Suspend

**Edit Description**

Fail this edit when a claim is submitted with a diagnosis or ICD-9 procedure code indicating an elective abortion was performed.

**Edit Criteria**

If a claim is submitted with a diagnosis code listed on diagnosis group 10 (see *Appendix A*) or ICD-9 procedure code listed on ICD-9 procedure group 4 (see *Appendix A*) indicating an elective abortion was performed, fail this edit.

**EOB Code**

4022 – Claim denied for additional information. If the abortion was performed for therapeutic or other Medicaid approved purposes, please resubmit the claim with a physician certification form and medical record documentation (H&P, discharge summary, OP note).

**ARC Code**

**17 - Payment adjusted because requested information was not provided or was insufficient/incomplete. Addition information is supplied using the remittance advice remarks codes whenever appropriate.**

**Remark Code**

**N29 - Missing documentation/orders/notes/summary/report/chart.**

**Method of Correction**

Route the claim to the medical policy specialist.

Medical policy specialist instructions:

Check for the presence of medical documentation. If no documentation is present, deny the claim.

If medical documentation is present, and it substantiates one of the diagnosis codes listed on diagnosis group 10 (see *Appendix A*), fail this edit with EOB 4022.

If a claim is not miscoded, the claim must be accompanied by the following:

- *Physician Certification for Abortion* form that states the abortion was necessary to preserve the life of the pregnant woman.
- Medical record that supports the physician's abortion certification statement.

If the documentation indicates abortion was performed following rape or incest, forward the claim and all attachments to the director of Medicaid operations. The medical policy specialist is to review all claims suspending for this edit with the medical policy manager. Each claim forwarded to Medicaid Operations will be entered on a tracking form maintained by the medical policy manager.

If certification and/or medical documentation is not attached or completed, deny the claim with EOB 4022.

If medical documentation and certification (including patient name, address, date of service, physician name and physician signature) are attached, override the error and force the claim to pay. A diagnosis is not required on the physician certification form.

Photocopy the claim, physician certification form, and medical record. File in the abortion file until needed for the quarterly abortion report.

**Edit: ESC 4027 Diagnosis Code Not Covered or Not Effective for Date of Service***Note: Edit 4027 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I, H, O	04	All	Detail	No	Yes	0

Disposition	I, H, O
Paper Claim	Suspend
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Suspend

**Edit Description**

Fail this edit if the diagnosis code billed is not covered for date of service, or not covered in the coverage field.

**Edit Criteria**

If the diagnosis code is not effective for the date of service billed, or the diagnosis code is on file for the date of service, but the coverage indicator = 'N', fail this edit with EOB 4027. To apply this edit, compare the covered period dates with the effective dates of the diagnosis code on the claim, or if it has an 'N' segment on the coverage field, fail this edit.

If only one diagnosis is indicated and it fails this edit, fail the edit. If there is more than one diagnosis, and at least one diagnosis is covered, do not fail this edit; bypass the edit.

**EOB Code**

4027 – The diagnosis code is invalid, or no longer effective for dates of service billed – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**M76 – Missing, incomplete, or invalid diagnosis or condition.**

***Method of Correction***

Check for keying errors and correct any errors found and resubmit the claim.

If no keying errors are found, fail this edit with EOB 4027.

**Edit: ESC 4029 Diagnosis Code/Place of Service Restriction***Note: Edit 4029 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	04	All except MRT and PASRR	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if the diagnosis code submitted on the claim is not valid on the Diagnosis/POS Restriction Table.

**Edit Criteria**

If the claim contains a diagnosis that is not a valid diagnosis found on the Diagnosis/POS Restriction Table, fail this edit with EOB 4029.

**EOB Code**

4029 – Diagnosis code versus place of service restriction. Diagnosis code is invalid place of service restriction – please verify and resubmit.

**ARC Code**

96 – Non-covered charge.

**Remark Code**

M77 – Missing, incomplete, or invalid diagnosis or condition.

**Method of Correction**

Claims failing with this edit will be systematically denied.

**Edit: ESC 4039 Diagnosis Cannot Be Used As Principal Diagnosis***Note: Edit 4039 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	04	All	Header	No	Yes	0

Disposition	I
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if the principal diagnosis is found in the grouper diagnosis table but the MDC in the table is equal to zero.

**Edit Criteria**

If the principal diagnosis on the claim is found in the grouper diagnosis table, but the MDC in the table is equal to zero, fail this edit with EOB 4039.

**EOB Code**

4039 – The diagnosis submitted as principal diagnosis is not valid as a principal diagnosis – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis (es) is (are) missing or invalid.**

**Remark Code**

**MA63 – Missing, incomplete, or invalid principal diagnosis.**

**Method of Correction**

Claims failing this edit will systematically deny

**Edit: ESC 4040 Primary Diagnosis Code Not on File***Note: Edit 4040 revised October 26, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, M, O	04	All	Header	No	Yes	0

Disposition	M, O, I, L	H
Other	Deny	Deny
Paper w/o attach	Suspend	Suspend
Paper w/attach	Suspend	Suspend
ECS w/o attach	Deny	Deny
ECS w/attach	Deny	Deny
Shadow	Pay	Pay
Point of Service w/o attach	Reject	Reject
Point of Service w/attach	Reject	Reject
Voids/Replacement non-check related	Deny	Inactive
Voids/Replacement check related	Deny	Inactive
Shadow Replacement	Pay	Pay
Mass Adj. Void Transaction	Deny	Deny
Mass Replacement NH	Deny	Inactive
Mass Replacement FIN	Deny	Inactive
Mass Adj. Reprocess by EDS SE	Deny	Deny
Replacement Processed by EDS SE	Deny	Deny
Elec. Replacement w/attach or claim note	Deny	Deny
Elec. Replacement w/o attach or claim note	Deny	Deny
Spend-down EOM auto-initiated Mass Replacement	Deny	Inactive
Shadow Mass Replacement	Deny	Deny
Payer Elec. Replacement	Deny	Deny
Claims Reprocessed by EDS SE	Deny	Deny
Special Projects	Suspend	Suspend

**Edit Description**

Fail this edit if the primary diagnosis code is not on the diagnosis table and the claim's provider specialty is not equal to 250, 260-266, or 350-354.

**Edit Criteria**

If the claim's primary diagnosis is not on the diagnosis table, and the provider specialty is not equal to 250 (DME/medical supply dealer), 260-266 (transportation), or 350-354 (waiver), fail this edit with EOB 4040.

### **EOB Code**

4040 – This (these) diagnosis(es) is (are) not covered, missing, or are invalid.

### **ARC Code**

47 – Missing/incomplete/invalid other diagnosis.

**D21 – This (these) diagnosis(es) are missing or are invalid.**

### **Remark Code**

M64 – The primary diagnosis code is not a valid diagnosis code – please verify and resubmit.

### **Method of Correction**

Claims failing this edit will be systematically denied.

For paper claims, check to see if the primary diagnosis code was keyed correctly. Correct as needed and resubmit (DO NOT FORCE). If the primary diagnosis was keyed correctly, then deny the edit.

**Edit: ESC 4041 Secondary Diagnosis Code Not on File**

<i>Note: Edit 4041 revised October 25, 2006</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, M, O	04	All, except MRT and PASRR	Header	No	Yes	0

Disposition	H, L, M, O	I
Other	Suspend	Suspend
Paper w/o attach	Suspend	Suspend
Paper w/attach	Suspend	Suspend
ECS w/o attach	Suspend	Deny
ECS w/attach	Deny	Deny
Shadow	Pay	Pay
Point of Service w/o attach	Reject	Reject
Point of Service w/attach	Reject	Reject
Voids/Replacement non-check related	Suspend	Inactive
Voids/Replacement check related	Suspend	Inactive
Shadow Replacement	Pay	Pay
Mass Adj. Void Transaction	Suspend	Suspend
Mass Replacement NH	Suspend	Inactive
Mass Replacement FIN	Suspend	Inactive
Mass Adj. Reprocess by EDS SE	Inactive	Suspend
Replacement Processed by EDS SE	Inactive	Suspend
Elec. Replacement w/attach or claim note	Deny	Deny
Elec. Replacement w/o attach or claim note	Suspend	Deny
Spend-down EOM auto-initiated Mass Replacement	Suspend	Inactive
Shadow Mass Replacement	Suspend	Suspend
Payer Elec. Replacement	Suspend	Deny
Claims Reprocessed by EDS SE	Suspend	Suspend
Special Projects	Suspend	Suspend

**Edit Description**

Fail this edit if the secondary diagnosis code is not in the diagnosis table and the claim's provider specialty is not equal to 250, 260-266, or 350-354.

### **Edit Criteria**

If the claim's secondary diagnosis is not on the diagnosis table, and the claim's provider specialty is not equal to 250 (DME/medical supply dealer), 260-266 (transportation), or 350-354 (waiver), fail this edit with EOB 4041.

### **EOB Code**

4041 – The secondary diagnosis code is not a valid diagnosis code – please verify and resubmit.

### **ARC Code**

47 – Missing/incomplete/invalid other diagnosis.

**D21 – This (these) diagnosis(es) are missing or are invalid.**

### **Remark Code**

M64 – The primary diagnosis code is not a valid diagnosis code – please verify and resubmit.

### **Method of Correction**

Claims failing this edit will be systematically denied.

For paper claims, check to see if the secondary diagnosis code was keyed correctly. Correct as needed and resubmit (DO NOT FORCE). If the secondary diagnosis was keyed correctly, then deny the edit.

**Edit: ESC 4042 Third Diagnosis Code Not on File***Note: Edit 4042 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, M, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, M, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	N/A
Special Batch	Deny

**Edit Description**

Fail this edit if the third diagnosis code is not in the diagnosis table and the claim's provider specialty is not equal to 250, 260-266, or 350-354.

**Edit Criteria**

If the claim's third diagnosis is not on the diagnosis table and the claim's provider specialty is not equal to 250 (DME/medical supply dealer), 260-266 (transportation), or 350-354 (waiver), fail this edit with EOB 4042.

**EOB Code**

4042 – The third diagnosis code is not a valid diagnosis code – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**M64 – Missing, incomplete, invalid, other diagnosis.**

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4043 Fourth Diagnosis Code Not on File***Note: Edit 4043 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, M, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, M, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	N/A
Special Batch	Deny

**Edit Description**

Fail this edit if the fourth diagnosis code is not in the diagnosis table and the claim's provider specialty is not equal to 250, 260-266, or 350-354.

**Edit Criteria**

If the claim fourth diagnosis is not on the diagnosis table and the claim's provider specialty is not equal to 250 (DME/medical supply dealer), 260-266 (transportation), or 350-354 (waiver), fail this edit with EOB 4043.

**EOB Code**

4043 – The fourth diagnosis code is not a valid diagnosis code – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**M64 – Missing, incomplete, invalid, other diagnosis.**

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4044 Diagnosis Versus Place of Service Mismatch***Note: Edit 4044 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	04	All except MRT and PASRR	Detail	No	Yes	0

Disposition	M
Paper Claim	Suspend
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Suspend

**Edit Description**

Fail this edit if the place of service is not valid for the diagnosis billed.

**Edit Criteria**

If the claim's place of service code is not valid for the diagnosis code billed, fail this edit with EOB 4044.

**EOB Code**

4044 – Treatment for this diagnosis is not covered when performed in the place of service billed – please verify and resubmit.

**ARC Code**

96 – Non-covered charge.

**Remark Code**

M77 – Missing, incomplete, invalid diagnosis or condition.

**Method of Correction**

Check for keying errors and correct any errors found.

If no errors are found, fail this edit with EOB 4044.

**Edit: ESC 4045 Diagnosis Code Not Covered or Not Effective for The Date of Service***Note: Edit 4045 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	04	All except MRT and PASRR	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Pay
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if all diagnosis codes billed are not covered.

**Edit Criteria**

If the diagnosis code is not effective for the date of service billed, or the diagnosis code is on file for the date of service but the coverage indicator = 'N', fail the edit with EOB 4045. To apply this edit, compare the service dates on the detail lines with the effective dates of the diagnosis code on the claim that corresponds to the diagnosis treated, or if it has a 'N' value in the coverage field, fail this edit with EOB 4045.

If only one diagnosis is indicated and it failed this edit, fail the edit. If there is more than one diagnosis, and at least one diagnosis is covered, do not fail the edit; bypass this edit.

Bypass this edit if the claim's provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), or **357- 360 (waiver) or 356 (TBI)**.

**EOB Code**

4045 – The diagnosis code is invalid or no longer effective for the date(s) of service – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

***Remark Code***

**M58 – Missing, incomplete, invalid claim information. Resubmit claim after correction.**

***Method of Correction***

Claims failing this edit will systematically deny.

**Edit: ESC 4046 Procedure Code Billed Prior to the Procedure Effective Date on File***Note: Edit 4046 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
A, D, H, I, M, O, Q	04	All	Detail	No	Yes	0

Disposition	A, D, H, I, M, O, Q
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if the procedure code billed is not effective for the dates of service on the claim.

**Edit Criteria**

If the date of service on the claim is prior to the procedure code's effective date (the very first time it was approved for Indiana Health Coverage Programs coverage) on the procedure code reference file, fail this edit with EOB 4046.

**EOB Code**

4046 – This date of service is prior to the procedure code's effective date – please verify and resubmit.

**ARC Code**

**181 – Payment adjusted because this procedure code was invalid on the date of service.**

**Remark Code**

**M151 – Missing, incomplete, or invalid procedure code.**

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4047 Fifth Diagnosis Code Not on File***Note: Edit 4046 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O, M	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O, M
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if the fifth diagnosis code is not on the diagnosis table.

**If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.**

**Edit Criteria**

If the claim fifth diagnosis is not on the diagnosis table, fail this edit with EOB 4047.

**If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.**

**EOB Code**

4047 – The fifth diagnosis code is not a valid diagnosis code – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**M64 – Missing, incomplete, or invalid other diagnosis.**

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4049 Seventh Diagnosis Code Not on File***Note: Edit 4049 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, O	04	All	Header	No	Yes	0

Disposition	H, I, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit when the seventh diagnosis code is not on the diagnosis table.

**Edit Criteria**

If the claim seventh diagnosis code is not on the diagnosis table, fail this edit with EOB 4049.

**EOB Code**

4049 – The seventh diagnosis code is not a valid diagnosis code – please verify and resubmit.

**ARC Code**

D21 – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

M77 – Missing, incomplete, or invalid diagnosis or condition.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4050 Eighth Diagnosis Code Not on File**

<i>Note: Edit 4050 revised October 25, 2006</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, O	04	All	Header	No	Yes	0

Disposition	H, I, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit when the eighth diagnosis code is not on the diagnosis table.

**Edit Criteria**

If the claim eighth diagnosis code is not on the diagnosis table, fail this edit with EOB 4050.

**EOB Code**

4050 – The eighth diagnosis code is not a valid diagnosis code – please verify and resubmit.

**ARC Code**

D21 – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

M64 – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4051 Ninth Diagnosis Code Not on File***Note: Edit 4051 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, O	04	All	Header	No	Yes	0

Disposition	H, I, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit when the ninth diagnosis code is not on the diagnosis table.

**Edit Criteria**

If the claim ninth diagnosis code is not on the diagnosis table, fail this edit with EOB 4051.

**EOB Code**

4051 – The ninth diagnosis code is not a valid diagnosis code – please verify and resubmit.

**ARC Code**

D21 – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

M64 – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4052 Admitting Diagnosis Code Not on File***Note: Edit 4052 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I, L	04	All	Header	No	Yes	0

Disposition	I	L
Paper Claim	CCF	CCF
ECS	Deny	Deny
Shadow	Deny	Deny
POS	CCF	CCF
Adjustments	Deny	N/A
Special Batch	CCF	CCF

**Edit Description**

Fail this edit when the admitting diagnosis code is not on the diagnosis table.

**Edit Criteria**

If the claim's admitting diagnosis is not on the diagnosis table, fail this edit EOB 4052.

**EOB Code**

4052 – The admitting diagnosis code is not a valid diagnosis code – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**MA65 – Missing, incomplete, or invalid admitting diagnosis(es).**

**Method of Correction**

For paper claims, a CCF will be systematically generated to the provider.

The CCF must be mailed back to EDS within 45 days. If not returned within 45 days, the claim will be systematically denied.

If the CCF is returned with corrected information, call up the suspended ICN and enter the corrected information in the proper field.

If the CCF is returned without any information, fail this edit with EOB 4052.

**Edit: ESC 4060 E-Code Not on File***Note: Edit 4060 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	<b>All except MRT and PASRR</b>	Header	No	Yes	0

Disposition	H, I, L, O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	CCF
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit when the E-code is not on file (ICD-9-CM).

**Edit Criteria**

If the E-code is not on the reference database (ICD-9-CM), fail this edit with EOB 4060.

**EOB Code**

4060 – The E-code billed is not a valid ICD-9-CM code – please verify and resubmit.

**ARC Code**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**MA76 – Missing, incomplete, or invalid diagnosis(es) or condition.**

**Method of Correction**

Claims failing this edit will systematically deny.

**Edit: ESC 4065 ICD-9-CM Procedure Code Requires Attachment***Note: Edit 4065 revised October 27, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I, L, O	04	<b>All except MRT and PASRR</b>	Header	Yes	Yes	0

Disposition	I, L, O
Paper Claim	Deny
Paper w/attach	Suspend
ECS	Deny
Shadow	Deny
POS	CCF
Adjustments	N/A
Special Batch	Deny

**Edit Description**

Fail this edit if the ICD-9-CM procedure code billed has an attachment indicator on the reference database and the claim has no attachments.

**Edit Criteria**

If the billed ICD-9-CM procedure code has an attachment indicator on the reference database and no attachment is submitted with the claim, fail this edit with EOB 4065.

**EOB Code**

4065 – ICD-9-CM procedure code billed requires an attachment – please verify and resubmit.

**ARC Code**

**16 – Claim or service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.**

**Remark Code**

**N29 - Missing documentation, orders, notes, summary, report, or chart.**

***Method of Correction***

Claims failing this edit will systematically deny.

**Edit: ESC 4067 Non-covered ICD-9-CM Procedure Code***Note: Edit 4067 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
I	04	All except MRT, PASRR, and First Steps	Header	Yes	Yes	0

Disposition	I	MRT, PASRR, First Steps
Paper Claim	Suspend	Deny
ECS	Deny	Deny
Shadow	Pay	Pay
POS	N/A	Pay
Adjustments	Suspend	Deny
Special Batch	Suspend	Deny

**Edit Description**

Fail this edit if the ICD-9-CM procedure code billed is non-covered.

**Edit Criteria**

If the ICD-9-CM procedure code billed is non-covered, and an approved PA is not on file, fail this edit with EOB 4067.

**EOB Code**

4067 – ICD-9-CM procedure code is non-covered – please verify and resubmit.

**ARC Code**

96 – Non-covered charge(s)

**Remark Code**

M51 – Missing, incomplete, or invalid procedure code(s).

**Method of Correction**

Check for keying errors and correct any errors found.

If no keying errors are found, fail this edit with EOB 4067.

**Edit: ESC 4090 Drug and Supply Codes Are Included in Treatment Room Rate***Note: Edit 4090 revised October 27, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
O	04	All	Detail	No	Yes	0

Disposition	O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if the following revenue codes (250, 251, 252, 257, 259, 27X) are billed in conjunction with a treatment room and the dates of service are on or after March 1, 1994.

**Edit Criteria**

If the following revenue codes (250, 251, 252, 257, 259, 27X) are billed in conjunction with a treatment room and the dates of service are on or March 1, 1994, fail this edit with EOB 4090.

**EOB Code**

4090 – Payment for 250, 251, 252, 257, 259, and 27 X drug and supply revenue codes are included in the treatment room reimbursement – please verify and resubmit.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4091 Add-On Service Was Billed Without a Treatment Room or Stand-Alone Service***Note: Edit 4091 revised October 27, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
O	04	All	Detail	No	Yes	0

Disposition	O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if add-on services (25X, 27X, 29X, 37X, 38X, 39X, 62X) are not billed with a treatment room or stand alone service and the service dates are on or after March 1, 1994.

**Edit Criteria**

If add-on services (25X, 27X, 29X, 37X, 38X, 39X, 62X) are billed without a treatment room revenue code listed on revenue group 3 (see *Appendix A*) or stand alone service revenue code listed on revenue group 4 (see *Appendix A*), and the service dates are on or after March 1, 1994, fail this edit with EOB 4091.

**EOB Code**

4091 – EOB These add on services (25X, 27X, 29X, 37X, 38X, 39X, 62X) are only payable when performed in conjunction with a treatment room, emergency room, or a stand alone procedure – please verify and resubmit.

**ARC Code**

**B15 - Payment adjusted because this procedure/service is not paid separately.**

**Remark Code**

**N29 - Missing documentation/orders/notes/summary/report/chart.**

***Method of Correction***

Claims failing this edit will be systematically denied.

**Edit: ESC 4098 RVU Not on File***Note: Edit 4098 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	04	All except PASRR	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if there is no relative value on the RBRVS listing.

**Edit Criteria**

If no relative value is on the RBRVS list table, fail this edit with EOB 4098.

**EOB Code**

4098 – Pricing being reviewed.

**ARC Code**

**181 – Payment adjusted because this procedure code was invalid on the date of service**

**Remark Code**

**M50 – Missing, incomplete, or invalid revenue code(s).**

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4117 OTCs Not Payable to Physicians***Note: Edit 4117 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
P, Q	04	All	Header	No	Yes	0

Disposition	P, Q
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if the drug code on the claim is an over-the-counter (OTC) product and the billing provider is not a pharmacist on the dispensed date.

**Edit Criteria**

If the NDC is classified as an OTC drug, and the billing provider type is not a pharmacist, type 24 with specialty of 240, or a DME/medical supplier, type 25 with specialty of 250, fail this edit with EOB 4117.

**EOB Code**

4117 – Over-the-counter items may be billed by pharmacists only.

**ARC Code**

**B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.**

**Remark Code**

**N95 - This provider type/provider specialty may not bill this service.**

**Method of Correction**

Claims failing this edit will be systematically denied

**Edit: ESC 4119 Revenue Code Not a Coronary or Noncoronary Service***Note: Edit 4119 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
O	04	All	Detail	No	Yes	0

Disposition	O
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if the revenue code is not a coronary or noncoronary service for old lab pricing.

**Edit Criteria**

If the revenue code is not a coronary code listed on revenue group 18 (see *Appendix A*), or noncoronary code listed on revenue group 19 (see *Appendix A*) for old lab pricing for blood products or related lab procedures, fail this edit with EOB 4106.

**EOB Code**

4119 – The revenue code billed is not a coronary or noncoronary service for blood products or related lab procedures.

**ARC Code**

**181 – Payment adjusted because this procedure code was invalid on the date of service**

**Remark Code**

**M50 – Missing, incomplete, or invalid revenue code(s).**

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4129 Twelfth Diagnosis Code Not on File (Header)**

<i>Note: Edit 0447 New effective October 25, 2006</i>
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Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Point of Service w/o attach	Reject
Point of Service w/attach	Reject
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the twelfth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the twelfth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4129.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4129** – The twelfth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4130 Thirteenth Diagnosis Code Not on File (Header)***Note: Edit 4130 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Point of Service w/o attach	Reject
Point of Service w/attach	Reject
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the thirteenth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the thirteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4130.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4130** – The thirteenth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4131 Fourteenth Diagnosis Code Not on File (Header)***Note: Edit 4131 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the fourteenth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the fourteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4131.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4131** – The fourteenth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4132 Fifteenth Diagnosis Code Not on File (Header)***Note: Edit 4132 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the fifteenth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the fifteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4132.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4132** – The fifteenth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4133 Fifteenth Diagnosis Code Not on File (Header)***Note: Edit 4133 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the sixteenth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the sixteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4132.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4133 – The sixteenth diagnosis code is not in the correct format – please verify and resubmit.**

**ARC Code**

**47 – This diagnosis is not covered, missing, or are invalid.**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**MA64 – Missing, incomplete, or invalid other diagnosis.**

**Method of Correction**

**Claims failing this edit will be systematically denied.**

**Edit: ESC 4134 Seventeenth Diagnosis Code Not on File  
(Header)***Note: Edit 4134 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the sixteenth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the sixteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4134.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4134** – The sixteenth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4136 Nineteenth Diagnosis Code Not on File (Header)***Note: Edit 4136 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the nineteenth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the nineteenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4136.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4136** – The nineteenth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4137 Twentieth Diagnosis Code Not on File (Header)***Note: Edit 4132 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Void/Rplc non-check related	Inactive
Void/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the twentieth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the twentieth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4137.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4137 – The twentieth diagnosis code is not in the correct format – please verify and resubmit.**

**ARC Code**

**47 – This diagnosis is not covered, missing, or are invalid.**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**MA64 – Missing, incomplete, or invalid other diagnosis.**

**Method of Correction**

**Claims failing this edit will be systematically denied.**

**Edit: ESC 4138 Twenty-First Diagnosis Code Not on File (Header)***Note: Edit 4138 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the twentieth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the twenty-first diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4138.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4138 – The twenty-first diagnosis code is not in the correct format – please verify and resubmit.**

**ARC Code**

**47 – This diagnosis is not covered, missing, or are invalid.**

**D21 – This (these) diagnosis(es) are missing or are invalid.**

**Remark Code**

**MA64 – Missing, incomplete, or invalid other diagnosis.**

**Method of Correction**

**Claims failing this edit will be systematically denied.**

**Edit: ESC 4139 Twenty-Second Code Not on File (Header)***Note: Edit 4139 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the twenty-second diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the twenty-second diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4139.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4139** – The twenty-second diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4140 Twenty-Third Code Not on File (Header)**

<i>Note: Edit 4140 New effective October 25, 2006</i>
---

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the twenty-third diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the twenty-third diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4140.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4140** – The twenty-second diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4142 Twenty Fifth Code Not on File (Header)***Note: Edit 4142 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the twenty-fifth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the twenty-second diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4142.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4142** – The twenty-fifth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4162 Tenth Diagnosis Code Not on File (Header)**

<i>Note: Edit 4162 New effective October 25, 2006</i>
---

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the tenth diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the tenth diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4162.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4162** – The tenth diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4163 Eleventh Diagnosis Code Not on File (Header)***Note: Edit 4163 New effective October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
H, I, L, O	04	All except MRT and PASRR	Header	No	Yes	0

Disposition	H, I, L, O
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Voids/Rplc non-check related	Inactive
Voids/Rplc check related	Inactive
Shadow Rplc	Deny
Mass Rplc Nursing Home	Inactive
Mass Rplc Financial	Inactive
Mass Rplc Reprocess by EDS SE	Inactive
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Inactive
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit if the eleventh diagnosis code is not in the diagnosis table.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**Edit Criteria**

If the eleventh diagnosis code is not three to five alphanumeric characters, fail this edit with EOB 4163.

If the provider specialty is equal to 250 (DME/medical supply dealer), 260-266 (transportation), 350-354 (waiver), and 356-360 (waiver) bypass this edit.

**EOB Code**

**4163** – The eleventh diagnosis code is not in the correct format – please verify and resubmit.

**ARC Code**

**47** – This diagnosis is not covered, missing, or are invalid.

**D21** – This (these) diagnosis(es) are missing or are invalid.

**Remark Code**

**MA64** – Missing, incomplete, or invalid other diagnosis.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4203 Denial Modifier for Non-covered MRO Services – Y8***Note: Edit 4203 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
M	04	<b>All except MRT and PASRR</b>	Detail	No	Yes	0

Disposition	M
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	N/A
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit if a procedure code is billed with modifier Y8.

**Edit Criteria**

If modifier Y8 is listed on the detail with a procedure code, fail this edit with EOB 4203.

**EOB Code**

4203 – This service is a non-covered Medicaid service as the rendering provider is not recognized by the Medicaid Program.

**ARC Code**

185 – The rendering provider is not eligible to perform the service billed.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4226 Third Modifier Not Valid for Dates of Service***Note: Edit 4226 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	00	All	Detail	No	Yes	0

Disposition	L
Paper Claim	Deny
ECS	Deny
Shadow	Deny
POS	Deny
Adjustments	Deny
Special Batch	Deny

**Edit Description**

Fail this edit when the third modifier is not valid for the dates of service.

**Edit Criteria**

If the claim's third modifier is not valid, for this edit with EOB 4226.

**EOB Code**

4226 – The third modifier is not valid for the dates of service. Please refer to Provider Manual to verify and resubmit.

**ARC Code**

B18- Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.

**181 – Payment adjusted because this procedure code was invalid on the date of service**

**Remark Code**

None.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4227 Fourth Modifier Not Valid for Dates of Service***Note: Edit 4227 revised October 25, 2006*

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
All	00	All	Detail	No	Yes	0

Disposition	L
Paper Claim	Deny
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ECS w/attach	Deny
Shadow	Deny
Point of Service w/o attach	Deny
Point of Service w/attach	Deny
Voids/Rplc non-check related	Deny
Voids/Rplc check related	Deny
Shadow Rplc	Deny
Mass Rplc Nursing Home	Deny
Mass Rplc Financial	Deny
Elec Rplc w/attach or clm note	Deny
Elec Rplc w/o attach or clm note	Deny
Spend-down Mass Rplc	Deny
Payer Elec Rplc	Deny

**Edit Description**

Fail this edit when the fourth modifier is not valid for the dates of service.

**Edit Criteria**

If the claim's fourth modifier is not valid, for this edit with EOB 4227.

**EOB Code**

4227 – The fourth modifier is not valid for the dates of service. Please refer to Provider Manual to verify and resubmit.

**ARC Code**

**182 – Payment adjusted because this procedure modifier was invalid on the date of service**

**Remark Code**

None.

**Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4234 First Modifier Not Valid for Claim Type (Detail)**

<i>Note: Edit 423 revised October 27, 2006</i>
--

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
O,M	00	All except MRT and PASRR	Detail	No	Yes	0

Disposition	O, M
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ESC w/o Attach	Deny
Shadow	Deny
Point of Service w/o Attach	Reject
Point of service w Attach	Reject
Voids/Replacement non-check related	Deny
Voids/Replacement check related	Deny
Shadow Replacement	Deny
Mass Replacement NH	Deny
Mass Replacement FIN	Deny
Elec. Replacement w/attach or claim note	Deny
Elec. Replacement w/o attach or claim note	Deny
Spend-down EOM auto-initiated Mass Replacement	Deny
Payer Elec. Replacement	Deny

**Edit Description**

Fail this edit when the first modifier is not valid for medical or outpatient claim types.

**Edit Criteria**

Modifiers 27, 73, and 74 are invalid as the first modifier for the medical claim. If submitted, fail this edit with EOB 4234.

Modifiers 25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79, 91, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, **GT**, LC, LD, LT, QM, QN, RC, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9 or TA are valid as the first modifier for the outpatient claim. If any other modifiers are submitted as the first modifier, fail this edit with EOB 4234

### **EOB Code**

4234 – First Modifier not valid for claim type.

### **ARC Code**

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

### **Remark Code**

M78 – Missing/Incomplete/Invalid HCPCS modifier

**N34 - Incorrect claim form/format for this service.**

### **Method of Correction**

Claims failing this edit will be systematically denied,

**Edit: ESC 4235 Second Modifier Not Valid for Claim Type (Detail)**

<i>Note: Edit 4235 revised October 27, 2006</i>
---

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
O, M	00	All except MRT and PASRR	Detail	No	Yes	0

Disposition	O, M
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ESC w/o Attach	Deny
Shadow	Deny
Point of Service w/o Attach	Reject
Point of service w Attach	Reject
Voids/Replacement non-check related	Deny
Voids/Replacement check related	Deny
Shadow Replacement	Deny
Mass Replacement NH	Deny
Mass Replacement FIN	Deny
Elec. Replacement w/attach or claim note	Deny
Elec. Replacement w/o attach or claim note	Deny
Spend-down EOM auto-initiated Mass Replacement	Deny
Payer Elec. Replacement	Deny

**Edit Description**

Fail this edit when the second modifier is not valid for medical or outpatient claim types.

**Edit Criteria**

Modifiers 27, 73, and 74 are invalid as the second modifier for the medical claim. If submitted, fail this edit with EOB 4234.

Modifiers 25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79, 91, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, **GT**, LC, LD, LT, QM, QN, RC, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9 or TA are valid as the second modifier for the outpatient claim. If any other modifiers are submitted as the first modifier, fail this edit with EOB 4234

### **EOB Code**

4235 – Second Modifier not valid for claim type.

### **ARC Code**

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

**N34 - Incorrect claim form/format for this service.**

### **Remark Code**

M78 – Missing/Incomplete/Invalid HCPCS modifier

### **Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4236 Third Modifier Not Valid for Claim Type (Detail)**

<i>Note: Edit 4236 revised October 27, 2006</i>
---

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
O,M	00	All except MRT and PASRR	Detail	No	Yes	0

Disposition	P
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ESC w/o Attach	Deny
Shadow	Deny
Point of Service w/o Attach	Reject
Point of service w Attach	Reject
Voids/Replacement non-check related	Deny
Voids/Replacement check related	Deny
Shadow Replacement	Deny
Mass Replacement NH	Deny
Mass Replacement FIN	Deny
Elec. Replacement w/attach or claim note	Deny
Elec. Replacement w/o attach or claim note	Deny
Spend-down EOM auto-initiated Mass Replacement	Deny
Payer Elec. Replacement	Deny

**Edit Description**

Fail this edit when the third modifier is not valid for medical or outpatient claim types.

**Edit Criteria**

Modifiers 27, 73, and 74 are invalid as the third modifier for the medical claim. If submitted, fail this edit with EOB 4234.

Modifiers 25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79, 91, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GT, LC, LD, LT, QM, QN, RC, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9 or TA are valid as the third modifier for the outpatient claim. If any other modifiers are submitted as the first modifier, fail this edit with EOB 4234

### **EOB Code**

4236 – Third Modifier not valid for claim type.

### **ARC Code**

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

### **Remark Code**

M78 – Missing, incomplete, or invalid HCPCS modifier

**N34 - Incorrect claim form or format for this service.**

### **Method of Correction**

Claims failing this edit will be systematically denied.

**Edit: ESC 4237 Fourth Modifier Not Valid for Claim Type (Detail)**

<i>Note: Edit 4237 revised October 27, 2006</i>
---

Claim Type	Location	Programs	Header/Detail	Overrideable	Allow Denial	Recycle Day
O, M	00	All except MRT and PASRR	Detail	No	Yes	0

Disposition	P
Other	Deny
Paper w/o attach	Deny
Paper w/attach	Deny
ECS w/o attach	Deny
ESC w/o Attach	Deny
Shadow	Deny
Point of Service w/o Attach	Reject
Point of service w Attach	Reject
Voids/Replacement non-check related	Deny
Voids/Replacement check related	Deny
Shadow Replacement	Deny
Mass Replacement NH	Deny
Mass Replacement FIN	Deny
Elec. Replacement w/attach or claim note	Deny
Elec. Replacement w/o attach or claim note	Deny
Spend-down EOM auto-initiated Mass Replacement	Deny
Payer Elec. Replacement	Deny

**Edit Description**

Fail this edit when the fourth modifier is not valid for medical or outpatient claim types.

**Edit Criteria**

Modifiers 27, 73, and 74 are invalid as the fourth modifier for the medical claim. If submitted, fail this edit with EOB 4234.

Modifiers 25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79, 91, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GT, LC, LD, LT, QM, QN, RC, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9 or TA are valid as the fourth modifier for the outpatient claim. If any other modifiers are submitted as the fourth modifier, fail this edit with EOB 4234

**EOB Code**

4237 – Fourth Modifier not valid for claim type.

**ARC Code**

16 – Claim/Service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.

**Remark Code**

M78 – Missing, incomplete, or invalid HCPCS modifier

**N34 - Incorrect claim form or format for this service.**

**Method of Correction**

Claims failing this edit will be systematically denied.